

IMMUNIZATON CONSENT FORM

Student's Name (Last): _____ First: _____ Middle: _____

Date of Birth: _____ Age: _____ Gender: M or F

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Message: _____

Parent/Legal Guardian's Name: _____ Mother's Maiden Name _____

School Name: _____ Grade _____

Ethnicity Hispanic / Not Hispanic / Unknown **Race** White / American Indian / Black / Alaskan Native / Asian / Hawaiian—Pac Islander / Other

Circle all that apply *Ages 0-18 yrs only*

Medicaid / No Insurance / Insurance / American Indian / Alaskan Native

Medicaid Information

Name (as printed on card): _____ Medicaid# _____

Primary Insurance

Patient's relationship to insured: Self Spouse Child

Insurance Company: _____ Name of Primary Insured: _____

Primary Insured's Date of Birth: _____ Insured Phone: _____

ID#: _____ Group #: _____

Insured's address if different from above: _____

PLEASE READ AND INITIAL:

_____ Central District Health Department will bill your health insurance or Medicaid.

_____ **IF YOU DO NOT** have insurance you will be billed directly for the administration fee(s).

_____ If you need financial assistance please answer the following:

Household size _____ Monthly Income _____

For billing questions please call our Finance Department at 327-8594.

FOR OFFICE USE ONLY

Payment Category: _____

Staff initials: _____

Insurance

Medicaid

Other

IMMUNIZATION SCREENING QUESTIONNAIRE

The following questions will help us determine which vaccines you may be given today. If a question is not clear, please ask a health care provider to explain it. Please circle YES or NO

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| Is the patient sick today? | YES | NO |
| Does the patient have allergies to medications, food, or any vaccine? (For example: eggs) Please list: _____ | YES | NO |
| Has the patient ever had a serious reaction after receiving a vaccine? (Routine or Flu vaccines) | YES | NO |
| Has the patient ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders? | YES | NO |
| Does the patient have cancer, leukemia, HIV/AIDS, immune system problems, or have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)? | YES | NO |
| Does the patient take cortisone, prednisone, other steroids, or anti-cancer drugs, or has the patient had x-ray treatments? Long term aspirin therapy? Daily aspirin dose _____. | YES | NO |
| During the past year , has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? If yes, when? month _____ day _____ | YES | NO |
| Has the patient received a MMR, Varicella, Rotavirus, or FluMist vaccine in the past four weeks ? If yes, when: month _____ day _____ | YES | NO |
| Does the patient have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? | YES | NO |
| Has the patient had chickenpox? If yes, when? _____ | YES | NO |
| Does the patient smoke? | YES | NO |
| For females: Are you pregnant or is there a chance you could become pregnant during the next month? | YES | NO |

ALL CLIENTS: PLEASE READ THE FOLLOWING, INITIAL, SIGN AND DATE

_____ Participation in and withdrawal from the Immunization Registry (IRIS) is voluntary. Call Idaho Immunization Program at 208.334.5931 to opt-out or withdraw. If you do not opt-out of IRIS in writing, your child's immunization records will be stored in the registry.

_____ I have read or had explained to me the Vaccine Information Statement for the Tdap and Meningococcal vaccine and understand the risks and benefits. I GIVE CONSENT to the Central District Health Department and its staff for my child named on the front of this form to be vaccinated for:

_____ TDAP Vaccine and/or _____ Meningococcal Vaccine

(If this consent form is not signed, dated, and returned, then your child will not be vaccinated)

Client/Guardian Signature: _____

(FOR NURSES USE ONLY)

(FOR NURSES USE ONLY)

Return Date _____

Date: _____

Nurse signature: _____